

EXHIBIT A

Patient Roster Attestation from Beginning of Uninsured Program to On Or About June 18, 2021

Patient Roster Attestation

- ☒ I have read and agree to the applicable HRSA COVID-19 Uninsured Program Terms and Conditions for [Testing](#) or [Treatment Services](#). I attest that I am authorized to agree to these terms on behalf of the provider with the Tax Identification Number associated with this attestation.
- ☒ I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 testing or care for the patient.
- ☒ I agree that I will accept the defined program reimbursement, as determined and/or adjustment by Health Resources & Services Administration (HRSA), as payment in full and will not balance bill the patient. I further understand that reimbursement is subject to available funding for the program.
- ☒ I acknowledge that I may be asked to submit to the review process established by HRSA, including its contractor to determine whether payments were made correctly. Additionally, upon request by HRSA or its contractor, I will provide any and all information related to the disposition or use of the funds received under the HRSA COVID-19 Uninsured Program for auditing and/or reporting purposes.

[Cancel](#)
Submit

Patient Roster Attestation from On or About June 18, 2021 to On or About December 17, 2021

Patient Roster Attestation

- ☒ I have read and agree to the applicable HRSA COVID-19 [Uninsured Program Terms and Conditions \(PDF\)](#). I attest that I am authorized to agree to these terms on behalf of the provider with the Tax Identification Number associated with this attestation.
- ☐ I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 testing or care for the patient.
- ☐ I agree that I will accept the defined program reimbursement, as determined and/or adjustment by Health Resources & Services Administration (HRSA), as payment in full and will not balance bill the patient. I further understand that reimbursement is subject to available funding for the program.
- ☐ I acknowledge that I may be asked to submit to the review process established by HRSA, including its contractor to determine whether payments were made correctly. Additionally, upon request by HRSA or its contractor, I will provide any and all information related to the disposition or use of the funds received under the HRSA COVID-19 Uninsured Program for auditing and/or reporting purposes.

[Cancel](#)
Submit

Patient Roster Attestation from On or About December 17, 2021 Until the End of the Uninsured Program

Patient Roster Attestation

- ☐ I have read and agree to the applicable HRSA COVID-19 [Uninsured Program Terms and Conditions \(PDE\)](#). I attest that I am authorized to agree to these terms on behalf of the provider with the Tax Identification Number associated with this attestation.
- ☐ I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 testing or care for the patient.
- ☐ For vaccine administration claims, I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 vaccine administration for the patient, or their only health care coverage at the time the services were provided was foreign health coverage.
- ☐ I agree that I will accept the defined program reimbursement, as determined and/or adjustment by Health Resources & Services Administration (HRSA), as payment in full and will not balance bill the patient. I further understand that reimbursement is subject to available funding for the program.
- ☐ I acknowledge that I may be asked to submit to the review process established by HRSA, including its contractor to determine whether payments were made correctly. Additionally, upon request by HRSA or its contractor, I will provide any and all information related to the disposition or use of the funds received under the HRSA COVID-19 Uninsured Program for auditing and/or reporting purposes.